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## **Economically Inactive EU Migrants and the UK's NHS: Unreasonable Burdens without Real Links?**

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### **Abstract**

*Under pressure to make healthcare provision more affordable, questions of access to healthcare have gained prominence in most countries in recent years. In light of these concerns, this article examines a grey area of EU law: can economically inactive EU migrants rely on entitlement to the UK's NHS to satisfy Directive 2004/38/EC's requirement for them to have "comprehensive sickness insurance"? In particular, it considers if the UK can rely on the EU law concepts of "unreasonable burden" or "real link" to restrict economically inactive EU citizens' access to the NHS. It finds that that neither concept effectively prevents those who are not "contributing" to public finances from accessing publicly funded healthcare. The article concludes by recommending EU-level coordination of responsibility for social security coverage in order to ensure that universal, residency-based healthcare systems like the NHS remain sustainable in a post-citizenship EU.*

### **Introduction**

As the sustainability of public services in most Member States has become an increasingly fraught political issue in the last decades,<sup>1</sup> numerous Member States have reconsidered their domestic rules governing access to public services, including health care services.<sup>2</sup> In the UK, the immigration

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<sup>1</sup> See, on health care in particular, Tamara K. Hervey, "The European Union's Governance of Health Care and the Welfare Modernization Agenda" (2008) 2 Regulation and Governance 103; Gareth Davies, "The Community's Internal Market-Based Competence to Regulate Healthcare: Scope, Strategies and Consequences" (2007) 14 M.J. 215, p. 217.

<sup>2</sup> This holds true for both countries that operate social insurance systems (see, inter alia, Pauline Rosenau and Christiaan Lako, "An Experiment with Regulated Competition and Individual Mandates for Universal Health

authorities have in recent years attempted to curb economically inactive migrants' reliance on the NHS<sup>3</sup>, in an effort to—as Theresa May put it in 2012—prevent “abuse” of the generous UK healthcare system.<sup>4</sup> In an EU context, such “abuse” takes the form of economically inactive EU citizen migrants relying on host State services, when their free movement rights (stemming from art. 20 and 21 TFEU, and further articulated in Directive 2004/38/EC, or the Citizens' Directive) are contingent on them having sufficient resources and comprehensive sickness insurance so as to *not* burden host State finances.<sup>5</sup>

Unfortunately, curbing EU citizens' access to the NHS is not a straight-forward exercise, as the Citizens' Directive also contains an obligation to extend equal treatment to all migrant EU citizens. Consequently, as long as economically inactive British nationals are entitled to access the NHS when they reside in the UK, EU nationals in equivalent circumstances generally are as well. There are only two recognized means to preclude economically inactive migrant EU citizens from relying on healthcare services like the NHS without violating EU law. Per the case law of the ECJ, Member States are exempt from extending equal treatment under the Citizens' Directive where migrant EU citizens fail to demonstrate a “real link” to the host State. Alternatively, where an EU migrant is

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Care: The New Dutch Health Insurance System” (2008) 33 J.H.P.P.L. 1031) and countries that operate national health services (see, for instance, Maija Saksli, “The Concept of Residence and Social Security: Reflections on Finnish, Swedish and Community Legislation” (2000) 2 E.J.M.L. 157).

<sup>3</sup> The “NHS” is used here as a collective term for the English, Welsh, Northern Irish and Scottish national health services; while independent, in regulating patient access they operate under identical legal principles (see fn. 28).

<sup>4</sup> Alex Barker, “Britain falls foul of Brussels over immigration” (*Financial Times*, 26 April 2012). *Ft.com*, <http://www.ft.com/cms/s/0/31fb56f8-8fca-11e1-beaa-00144feab49a.html> [Accessed April 9, 2014].

<sup>5</sup> Directive 2004/38/EC of the European Parliament and of the Council of 29 April 2004 on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States [2004] O.J. L158/77, art. 7.

found to be an “unreasonable burden” on the host State public finances, their right to reside under the Citizens’ Directive can be revoked. However, what constitutes an “unreasonable burden”, or how a “real link” can be demonstrated, is unfortunately—after more than 20 years of case law on EU citizenship—still unclear.

This article will explore the concepts of “unreasonable burden” and “real link”, using EU migrant access to the NHS as a case study. First, it will outline when economically inactive EU citizens are permitted to exercise their art. 21 TFEU right to reside in a host Member State. Following this, a brief discussion of how access to public health care is regulated at the EU level and in UK domestic law will lead to an examination of existing EU-compliant possibilities for preventing economically inactive EU migrants from using the NHS. The article concludes that it is not clear if access to a residency-based universal healthcare system can be comfortably restricted using either the “unreasonable burden” or “real link” doctrines. Without a solution at the EU level that allocates responsibility for healthcare coverage to the Member States, residency-based public healthcare systems that are free at the point of delivery have come under significant pressure in the post-citizenship EU.

### **Residency Rights for Economically Inactive EU Migrants and Access to Social Benefits**

The requirement for economically inactive EU migrants to be self-sufficient has been present since Directives on the free movement rights of economically inactive migrants were first proposed by the Council.<sup>6</sup> The 1990s residence Directives for pensioners, students, and voluntarily unemployed EU nationals required their subjects to have “sufficient resources to avoid becoming a burden on the

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<sup>6</sup> Proposal for a Council Directive on the right of residence for students. Proposal for a Council Directive on the right of residence for employees and self-employed persons who have ceased their occupational activity. Proposal for a Council Directive on the right of residence (1989) COM(89)275 final, art. 1.

social assistance system” of the host State and “sickness insurance in respect of all risks” in the host State.<sup>7</sup>

As is typical of directives, the wording of these requirements is general enough so as to be adaptable to the specific legal situation in each Member State. The requirement for “sickness insurance in respect of all risks”, however, was never clarified in secondary legislation or in guidance. “All risks” was an absolute requirement, and one that ignored that national healthcare systems supplied different levels of coverage. In countries where there was both basic and supplementary cover available, it is unclear which of these was required.<sup>8</sup>

Uncertainty surrounding what constitutes appropriate “sickness insurance” has not diminished with the advent of the Citizens’ Directive. “Comprehensive” is possibly a less stringent requirement than “all risks”, but it is not a significant clarification. This remains problematic, because the requirement for “sickness insurance” has to be applied by national authorities in such a way so that economically inactive migrants and their families can demonstrate that they possess it.<sup>9</sup>

To date, EU secondary legislation has not specified the level of coverage needed by the requirement, nor has the ECJ’s case law offered clarification. In *Baumbast*, the ECJ confirmed that both the “sickness insurance” requirement and the “sufficient resources” requirement are included in the Directive to prevent economically inactive migrants who “become an ‘unreasonable’ burden on the

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<sup>7</sup> art. 1 of Council Directive 90/364/EEC of 28 June 1990 on the right of residence [1990] OJ L180/26 and Council Directive 93/96/EEC of 29 October 1993 on the right of residence for students [1993] OJ L317/59, art. 1(1) of Council Directive 90/365/EEC of 28 June 1990 on the right of residence for employees and self-employed persons who have ceased their occupational activity [1990] OJ L180/28.

<sup>8</sup> For instance, also covering dentistry and physical therapy, as it does in Ireland; see Sarah Thomson and Elias Mossialos, “Private Health Insurance and the Internal Market” in Elias Mossialos and others (eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (Cambridge: CUP, 2010).

<sup>9</sup> arts. 8 and 9 of the Citizens’ Directive.

public finances of the host Member State” from exercising a right to reside.<sup>10</sup> Following this, the ECJ held that any limitations on the right to reside must be proportionate.<sup>11</sup> In the case in question, Mr. Baumbast had medical insurance in Germany, but this insurance did not cover emergency care in the UK. The ECJ held that denying Mr. Baumbast residency rights on this lack of coverage would be disproportionate.<sup>12</sup>

*Baumbast* helps formulate a notion of comprehensive sickness insurance: the phrasing of the 1990s Directives may have demanded “insurance against all risks”, but the ECJ in *Baumbast* made it clear host States cannot require economically inactive EU migrants to demonstrate literal compliance with this requirement.<sup>13</sup> It is likely that the Citizens’ Directive’s amended requirement for simply “comprehensive” sickness insurance is a response to this need to consider proportionality. However, *Baumbast* cannot be taken to mean that all private insurance, regardless of coverage levels, is “comprehensive” sickness insurance. Complete clarity thus cannot be extracted from this case any more than from the amended requirement in the Citizens’ Directive.

Only recently has the Commission offered guidance on how to interpret the requirement for comprehensive sickness insurance. Section 3.2.3 of the 2009 Communication on *Guidance for better transposition and application of Directive 2004/38/EC* offers the following suggestions on how to interpret this requirement:

“Any insurance cover, private or public, contracted in the host Member State or elsewhere, is acceptable in principle, as long as it provides comprehensive

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<sup>10</sup> *Baumbast and R v Secretary of State for the Home Department* (C-413/99) [2002] E.C.R. I-07091, para. 90.

<sup>11</sup> *Baumbast* [2002] E.C.R. I-07091, paras 90-91.

<sup>12</sup> *Baumbast* [2002] E.C.R. I-07091, para. 93.

<sup>13</sup> See also Anne Pieter van der Mei, *Free Movement of Persons Within the European Community: Cross-Border Access To Public Benefits* (Oxford: Hart, 2003), p. 262.

coverage and does not create a burden on the public finances of the host

Member State.”<sup>14</sup>

Unfortunately, this guidance does little to resolve the uncertainty. In fact, the second part of the guidance’s stated requirement —comprehensive coverage that *does not create a burden on the public finances of the host Member State*—is at best unclear. The wording echoes recitals 10 and 16 of the Citizens’ Directive’s preamble, which suggest that requiring economically inactive EU citizens to be self-sufficient is a reflection on Member State concerns that these citizens will otherwise simply migrate to Member States with the most generous benefits arrangements.<sup>15</sup> However, it is unclear if the Commission is implying that some forms of comprehensive cover *are*, in fact, a burden on public finances of the host Member State, or if it simply means that coverage must be comprehensive *so that* a burden on the public finances of the host Member State can be avoided.

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<sup>14</sup> Communication on guidance for better transposition and application of Directive 2004/38/EC on the right of citizens of the Union and their family members to move and reside freely within the territory of the Member States COM(2009) 313 final.

<sup>15</sup> See Andrew George, “A View From the UK” (2007) 14 M.J. 213; see generally van der Mei, *Free Movement of Persons Within the European Community: Cross-Border Access To Public Benefits* (2003), pp. 12-13, 27-28; Siofra O’Leary, *The Evolving Concept of Community Citizenship: From the Free Movement of Persons to Union Citizenship* (The Hague: Kluwer Law International, 1996), pp. 131-132; Kay Hailbronner, “Union Citizenship and Access to Social Benefits” (2005) 42 C.M.L.Rev 1245; Tamara K. Hervey, “Social Solidarity: A Buttress Against Internal Market Law?” in Jo Shaw (ed), *Social Law and Policy in an Evolving European Union* (Oxford: Hart, 2000); Siofra O’Leary, “Solidarity and Citizenship Rights in the Charter of Fundamental Rights of the European Union” in Gráinne De Búrca (ed), *EU Law and the Welfare State: in Search of Solidarity* (Oxford: OUP, 2005), p. 64 onward; Tamara K. Hervey, “Mapping the Contours of European Union Health Law and Policy” (2002) 8 E.P.L. 69, 77-79; Laura Nistor, *Public Services and the European Union: Healthcare, Health Insurance and Education Services* (The Hague: TCM Asser, 2011), p. 283; Jo Shaw, Nina Miller and Maria Fletcher, *Getting to Grips with EU Citizenship: Understanding the Friction Between UK Immigration Law and EU Free Movement Law* (Edinburgh: Edinburgh Law School Citizenship Studies, 2013), pp. 26-27.

The second interpretation of this requirement seems more likely in light of the Commission's in-progress infringement proceedings against the UK,<sup>16</sup> to be discussed below. However, this is not immediately obvious from the Communication's wording. What constitutes an 'unreasonable burden' is thus at the heart of any evaluation of whether an economically inactive EU citizen has *comprehensive* sickness insurance, but the Communication does not clarify how such an evaluation is meant to take place at the Member State level.

In summary, though economically inactive EU citizens who are exercising their free movement rights have been expected to hold "sickness insurance" cover in their host Member State since 1990, the EU has to date failed to clarify what this requirement entails. Before evaluating the practical problems this results in for national health services, the article will now briefly outline how EU law can affect health care provision in the Member States—both in theory and in practice.

### **The EU Legislative Framework for the Regulation of Health Care**

Generally, Article 168(7) TFEU (ex 152 TEC) states that the EU has no competence to regulate the setup or financing of public health care systems in Member States; at most, under Article 168 TFEU, the EU can encourage Member States to cooperate in efforts to improve public health.<sup>17</sup> However,

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<sup>16</sup> Commission, "Free movement: Commission asks the UK to uphold EU citizens' rights (IP/12/417)" (2012).

*Europa.eu*, [http://europa.eu/rapid/press-release\\_IP-12-417\\_en.htm](http://europa.eu/rapid/press-release_IP-12-417_en.htm) [Accessed April 9, 2014].

<sup>17</sup> See Elias Mossialos and others, "Health Systems Governance in Europe: The Role of European Union Law and Policy" in *Health Systems Governance in Europe: The Role of European Union Law and Policy* (2010); Derrick Wyatt, "Community Competence to Regulate Medical Services" in Michael Dougan and Eleanor Spaventa (eds), *Social Welfare and EU Law* (Oxford: Hart, 2005); van der Mei, *Free Movement of Persons Within the European Community: Cross-Border Access To Public Benefits* (2003), p. 228; Tamara K. Hervey and Jean V. McHale, *Health Law and the European Union* (Cambridge: CUP, 2004), Chapter 3; Ulla Neergaard, "EU Health



the free movement rules have frequently had a knock-on effect on what regulation of an area in which the EU Member States retain exclusive competence can look like in practice.

Regarding the free movement of services, the health care systems of the Member States have had to adapt to ECJ jurisprudence that gave EU citizens a right to access health care in other EU Member States as “users” of health services. The ECJ’s cross-border health-care case law commencing with *Decker*<sup>18</sup> and *Kohll*<sup>19</sup> eventually culminated in even the NHS being told that it must both authorize and reimburse cross-border treatment for patients under its ‘cover’ where treatment at home was not possible within a medically acceptable time in *Watts*.<sup>20</sup> This line of case law has been long-discussed in the academic literature, frequently critically so.<sup>21</sup> The fact that the NHS had no financial

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Care Law in a Constitutional Light: Distribution of Competence, Notions of 'Solidarity', and 'Social Europe'” in Johan Willem van de Gronden and others (eds), *Health Care and EU Law* (The Hague: TCM Asser, 2011).

<sup>18</sup> *Nicolas Decker v Caisse de maladie des employés privés* (C-120/95 ) [1998] E.C.R. I-01831

<sup>19</sup> *Raymond Kohll v Union des caisses de maladie* (C-158/96) [1998] E.C.R. I-01931

<sup>20</sup> *The Queen, on the application of Yvonne Watts v Bedford Primary Care Trust and Secretary of State for Health* (C-372/04) [2006] E.C.R. I-04325

<sup>21</sup> See, inter alia, Julio Baquero Cruz, 'The Case Law of the European Court of Justice on the Mobility of Patients: An Assessment' in *Health Care and EU Law* (2011); Vassilis Hatzopoulos, 'Killing National Health and Insurance Systems but Healing Patients? The European Market for Health Care Services after the Judgments of the ECJ in *Vanbraekel* and *Peerbooms*' (2002) 39 *Common Market Law Review* 683; Christopher Newdick, 'Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity' (2006) 43 *Common Market Law Review* 1645; Panos Koutrakos, 'Healthcare as an Economic Service under EC Law' in *Social Welfare and EU Law* (2005); Klaus Sieveking, 'ECJ Rulings on Health Care Services and Their Effects on the Freedom of Cross-Border Patient Mobility in the EU' (2007) 9 *European Journal of Migration and Law* 25; Christopher Newdick, 'The ECJ, Trans-national Health Care and Social Citizenship: Accidental Death of a Concept' (2008) 26 *Wisconsin International Law Journal* 844; Johan Willem van de Gronden, 'Cross-Border Health Care in the EU and the Organization of the National Health Care Systems of the Member States: the

mechanism in place to reimburse treatment abroad given that no “payment” for treatment ever took place domestically was swept aside by the ECJ, which on that point simply stated that “the need for the Member States to reconcile the principles and broad scheme of their healthcare system with the requirements arising from the Community freedoms entails ... a duty on the part of the competent authorities of a national health service, such as the NHS, to provide mechanisms for the reimbursement of the cost of hospital treatment in another Member State”.<sup>22</sup> Only in 2011 have the Member States—after significant legislative delay—managed to orchestrate a concerted response, by introducing the Patients’ Rights Directive: a codification of the cross-border health-care rights for patients that to an extent curtails the most invasive aspects of the ECJ’s case law.<sup>23</sup>

On the subject of free movement of persons, significant interference stems from Regulation 883/2004, coordinating social security for migrant EU citizens so as to ensure they do not lose social security entitlements on relocating to another Member State.<sup>24</sup> Regulation 883/2004 aims to ensure that no EU citizens are covered by two social security systems at once, and this includes economically inactive migrants.<sup>25</sup> Consequently, EU migrants currently or previously engaged in “economic activity” are to be covered only by the legislation of the Member State where they

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Dynamics Resulting from the European Court of Justice's Decisions on Free Movement and Competition Law' (2008) 26 Wisconsin International Law Journal 705.

<sup>22</sup> *Watts* [2006] E.C.R. I-04325, para. 122.

<sup>23</sup> Vassilis Hatzopoulos and Tamara K. Herve, 'Coming into line: the EU's Court Softens on Cross-Border Health Care' (2013) 8 Health Economics, Policy and Law 1; see generally, Stephane De La Rosa, 'The Directive on Cross-Border Healthcare or the Art of Codifying Complex Case Law' (2012) 49 Common Market Law Review 15

<sup>24</sup> See generally Paul Schoukens and Danny Pieters, “The Rules Within Regulation 883/2004 For Determining the Applicable Legislation” (2009) 11 E.J.S.S. 81.

<sup>25</sup> Regulation 883/2004, art. 11(1).

engage(d) in said activity,<sup>26</sup> and as a residual coordinating measure, the Regulation states that all other EU nationals are covered by legislation of the Member State in which they reside.<sup>27</sup>

Residence here refers to “habitual residence”, or where a migrant’s centre of interests lies. A determination of where a migrant habitually resides is to be made by the host State authorities on the basis of factual information presented by the migrant, covering any number of aspects of the migrant’s life: family situation, length of stay in the host State, employment situation, activities engaged in (such as studying), etc.<sup>28</sup> Migrants *must* be “resident” in at least one Member State for the coordinating system to work; and the investigation *can* find that an economically inactive migrant is “resident” in the host State, which would then be responsible for that migrant’s health care even where the migrant has never contributed to social security *in* the host State.

As noted, the cross-border patient case law has received substantial academic attention, but the effect that the EU free movement of persons rule can have on the regulation of health care has not received much attention to date. The remainder of this article will show how the interplay of Regulation 883/2004 and the Citizenship Directive can affect organisation of national health care setup and financing, using the NHS as a case study.

## **The UK System of Health Care**

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<sup>26</sup> Regulation 883/2004, art. 11(3)(a)-(d).

<sup>27</sup> Regulation 883/2004, art. 11(3)(e).

<sup>28</sup> See Regulation (EC) No 987/2009 of the European Parliament and of the Council of 16 September 2009 laying down the procedure for implementing Regulation (EC) No 883/2004 on the coordination of social security systems [2009] OJ L284/1, art. 11, and Commission, 'Practical guide on the applicable legislation in the European Union (EU), the European Economic Area (EEA) and in Switzerland' (*europa.eu*, December 2013) <<http://ec.europa.eu/social/BlobServlet?docId=11366&langId=en>> accessed 27 April 2014, p. 41-44.

Though each Member State has a distinct method of both funding and organizing access to its public healthcare system, we can nonetheless observe that generally, Member States have operated public healthcare in two distinct styles that have been affected by EU law in different ways.<sup>29</sup> First, there are Member States who operate systems wherein the population 'buys' access to the healthcare system through a form of insurance. The insurance can be publically operated or privately operated, under competitive market conditions where different levels of coverage are available from different providers. While choice is available in a system with competing private insurance providers, the insurance-based public healthcare model nonetheless presupposes that insurance is *mandatory*. Financially, such a system only works if everyone who uses it buys the insurance, either directly or through government credit. This system is generally known as the 'social insurance' model of public healthcare financing and operation, and is found (in various forms) in Germany, Austria, France, and the Benelux countries, amongst others.

The European legislation on free movement of economically inactive migrants appears to presuppose that national healthcare systems work on an insurance basis. Until the late 1970s, all six original Member States operated insurance-style systems, albeit in different ways. Most States that

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<sup>29</sup> For detailed commentary on the structuring and financing of Member State healthcare systems, see, inter alia, Adam Oliver and Elias Mossialos, "European Health Systems Reforms: Looking Backward to see Forward?" (2005) 30 J.H.P.P.L. 7; Vassilis Hatzopoulos, "Health Law and Policy: The Impact of the EU" in *EU Law and the Welfare State: in Search of Solidarity* (2005); Scott L. Greer, *The Politics of European Union Health Policies* (Maidenhead: Open University Press, 2009); Willy Palm and others, *Implications of Recent Jurisprudence on the Co-ordination of Health Care Protection Systems* (Brussels: Association Internationale de la Mutualite (AIM), 2000); Wyatt, "Community Competence to Regulate Medical Services" in *Social Welfare and EU Law* (2005), pp. 135-138; Nistor, *Public Services and the European Union: Healthcare, Health Insurance and Education Services* (2011), Chapter 2; Christopher Newdick, "Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity" (2006) 43 C.M.L.Rev 1645.

have acceded to the EU from the 1970s, however, organise their healthcare systems as ‘national health services’.<sup>30</sup> While accession of these countries predates the 1990s Residency Directives, it postdates the social security coordination regulations that established the terminology still used at the EU level to discuss social security benefits: as early as 1958, the Council enacted the predecessor of Regulation 883/2004, which ensured that any EU national worker covered by social security (including healthcare services) in their home State could use host State social security services when working there.<sup>31</sup>

Regulation 3/1958 is worded in terms of insurance: for instance, arts. 16 and 17 of the regulation, titled “Sickness, Maternity”, describe how “insurance” benefits should be aggregated for a migrant worker; and art. 19(4) of the regulation discusses the possibility that a Member State may offer more than one “sickness insurance policy”, and makes it clear that migrant EU workers should be covered by the policy that nationally would cover those doing manual work in the steel industry.

Prior to the accession of the UK, Ireland and Denmark, Regulation 3/1958 was repealed by Regulation 1408/71,<sup>32</sup> coordinating the social security schemes of EU national workers and their families when moving within the Community.<sup>33</sup> Regulation 1408/71 and its successor, Regulation

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<sup>30</sup> Italy switched to a national health service in 1978. One exception is Austria, but it did not accede to the EU until 1995; Spain and Greece started operating national health services by the time they acceded. See Oliver and Mossialos, “European Health Systems Reforms: Looking Backward to see Forward?” (2005) 30 J.H.P.P.L. 7, 14.

<sup>31</sup> Règlement n° 3 concernant la sécurité sociale des travailleurs migrants [1958] OJ L30/561.

<sup>32</sup> Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community [1971] OJ L149/2.

<sup>33</sup> See also Dragana Damjanovic and Bruno De Witte, “Welfare Integration through EU Law: the Overall Picture in the Light of the Lisbon Treaty” in Ulla Neergaard, Ruth Nielsen and Lynn M. Roseberry (eds), *Integrating Welfare Functions into EU Law: From Rome to Lisbon* (Copenhagen: DJØF, 2009), pp. 60-61.

883/2004,<sup>34</sup> are also drafted with a vocabulary that emphasises social “insurance”; both retain the language of Regulation 3/1958 when discussing “Sickness and Maternity” in Title III, Chapter 1.

Given that all EU Member States first coordinating social security operated a social insurance model welfare State, it is plausible that current-day terms used in EU secondary legislation to refer to healthcare policy within Member States are rooted in that tradition as well.<sup>35</sup>

Under the national health service model, however, citizens are not *insured* against illness, but rather benefit from universal coverage by a State-funded healthcare system. These types of public healthcare systems do not collect individual contributions through employment, as insurance-based models do, but rather are funded indirectly through taxation in a variety of ways. In practical operation, many parts of such a national health system are transaction-free. Whereas in a social insurance system, insurance providers and citizens directly communicate about the cost of treatment and the general contribution to the health-care system the citizen must make on an annual basis, in a national health service system, citizens benefit from treatment that is “free at the point of use”, as no payment visibly exchanges hands from the patient to the care provider.<sup>36</sup>

As discussed, the precise meaning of healthcare “insurance” has not been addressed by the EU legislators or the ECJ, although the Commission issued a reasoned opinion to the UK in April 2012 that states the following:

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<sup>34</sup> Regulation (EC) No 883/2004 of the European Parliament and of the Council of 29 April 2004 on the coordination of social security systems [2004] OJ L166/1.

<sup>35</sup> Schoukens and Pieters, “The Rules Within Regulation 883/2004 For Determining the Applicable Legislation” (2009) 11 E.J.S.S. 81, p. 104-105, make this point generally regarding the logic underpinning EU social security coordination.

<sup>36</sup> Some medical services, such as optometry, dentistry and payments for prescription medication, may require a patient contribution; but primary and secondary treatment is normally not charged for. This differs per country; see generally Palm and others, *Implications of Recent Jurisprudence on the Co-ordination of Health Care Protection Systems* (2000).

“Under the Free Movement Directive, EU citizens who settle in another EU country but do not work there may be required to have sufficient resources and sickness insurance. The United Kingdom, however, does not consider entitlement to treatment by the UK public healthcare scheme (NHS) as sufficient. This breaches EU law.”<sup>37</sup>

The Commission thus appears to view the NHS as a comprehensive sickness insurance *provider* despite the fact that it does not provide *insurance*. This classification has significant repercussions in light of how entitlement to treatment under the NHS (and other national health services) is normally organized.

### *NHS Entitlement*

The relevant provisions on entitlement to treatment by the NHS in England are set out in the NHS Act 2006 and the NHS (Charging of Overseas Visitors) Regulations 2011.<sup>38</sup> Under the NHS Act 2006, anyone who is “ordinarily resident” in the UK is entitled to use the NHS for free: section 1(3) states that “free” service is obligatory for all those entitled to use it, unless otherwise noted. An exception is contained in section 175, which entitles the UK authorities to introduce additional legislation to recover charges from “overseas visitors”.

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<sup>37</sup> Commission, “Free movement: Commission asks the UK to uphold EU citizens' rights (IP/12/417)”.

<sup>38</sup> The National Health Service (Charges to Overseas Visitors) Regulations 2011 (SI 2011/1556); equivalent legislation exists in Wales (National Health Service (Wales) Act 2006 and National Health Service (Charges to Overseas Visitors) Regulations 1989 (SI 1989/306), as amended), Scotland (National Health Service (Scotland) Act 1978 and The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 (SI 1989/364), as amended) and Northern Ireland (Health and Personal Social Services (Northern Ireland) Order 1972 (SI 1972/1265), as amended, and Provision of Health Services to Persons not Ordinarily Resident Regulations (Northern Ireland) 2005 (SI 2005/551), as amended).

The NHS Act 2006 does not define “ordinary residence”, but Department of Health guidance directs NHS employees to apply *R v Barnet LBC Ex. p Shah*<sup>39</sup> when deciding if a visitor is to be charged.<sup>40</sup> In *Shah*, Lord Scarman ruled that anyone adopting an ‘abode’ voluntarily and for settled purposes “as part of the regular order of his life”, regardless of how long, would pass an “ordinary residence” test unless said person’s stay in the UK was unlawful.<sup>41</sup> This ruling was made in the context of the UK’s Education Acts, but—as the Department of Health Guidance states—“is generally recognized to have a wider application.”<sup>42</sup>

This definition would embrace most, if not all, migrant EU citizens. It is true that economically inactive migrants do not have an unrestricted right to reside in host Member States: as discussed above, Art. 7(1) of the Citizens’ Directive requires economically inactive EU citizens to have sufficient resources and comprehensive sickness insurance before they have a right to reside for longer than 3 months.<sup>43</sup> However, the NHS Act 2006 and the definition given to the term “ordinary residence” produce a sequencing issue. When a self-sufficient EU citizen arrives with sufficient resources in the UK, as well as an intention to stay in the UK for “settled purposes”, the NHS Act 2006 entitles him or

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<sup>39</sup> *R v Barnet LBC, ex p Shah* [1983] 2 AC 309, [1983] 2 WLR 16

<sup>40</sup> Department of Health, “Guidance on Implementing the Overseas Visitors Hospital Charging Regulations” (October 2013) <http://www.dh.gov.uk/publications> [Accessed April 9, 2014], para. 3.4.

<sup>41</sup> *Shah* [1983] 2 AC 309, p. 343.

<sup>42</sup> Department of Health, “Guidance on Implementing the Overseas Visitors Hospital Charging Regulations”, para. 3.4.

<sup>43</sup> See Anthony Valcke, “Five Years of the Citizens’ Directive in the UK: Part 2” (2011) 25 J.I.A.N.L. 331, considering this issue from the perspective of UK non-compliance with Directive 2004/38/EC.



her to NHS treatment free of charge. The requirement for “comprehensive sickness insurance” would thus appear automatically satisfied for nearly all EU migrants intending to *live* in the UK.<sup>44</sup>

### *Coverage for “Overseas Visitors”*

The NHS access rights conundrum is exacerbated by the UK rules which permit recovery of NHS healthcare costs, which are laid down in the NHS (Charging of Overseas Visitors) Regulations 2011. While there is an argument to be made that economically inactive EU citizens should not be able to pass an “ordinary residence” test unless they are not reliant on the NHS (and thus not burdening UK public funds), domestic regulation makes free healthcare explicitly available for “exempt” overseas visitors in nearly all situations that would cover economically inactive EU migration.

First of all, the NHS (Charging of Overseas Visitors) Regulations 2011 exempt all students registered on a substantially State-funded degree course lasting for more than 6 months from NHS charges.<sup>45</sup> This is reinforced by the Department of Health’s guidance on this point, which stresses that *if* a student presents an European Health Insurance Card (EHIC), granted by their home Member State under Regulation 883/2004, the NHS can reclaim treatment costs from their home State competent institution—but that “a student does not have to have an EHIC to prove entitlement under the student exemption.”<sup>46</sup> Additional exemptions exist for all residents who have lawfully resided in the UK for longer than twelve months,<sup>47</sup> and finally, all direct family members (ie, spouses, children) of other ‘exempt visitors’ are also entitled to free NHS care.<sup>48</sup>

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<sup>44</sup> See Department of Health, “Guidance on Implementing the Overseas Visitors Hospital Charging Regulations”, paras 3.5-3.13, which stresses that there is no minimum residency period to become ‘ordinarily resident’.

<sup>45</sup> 2011 Regulations, reg 8(2)(d).

<sup>46</sup> Department of Health, “Guidance on Implementing the Overseas Visitors Hospital Charging Regulations”, para. 3.41.

<sup>47</sup> 2011 Regulations, reg 7(1).

In conclusion, under domestic UK law on health-care access, all economically inactive EU citizens are entitled to free NHS treatment after having resided in the UK for *twelve months*. In the case of students enrolled in a degree that lasts longer than 6 months, the entitlement begins on the day they arrive to study.

## **UK Implementation and Application of EU Law**

### *UK Interpretations of Directive 2004/38 and Comprehensive Sickness Insurance*

To compensate for the very generous “free NHS health care for residents” legislation in force in the UK, the UK authority charged with supplying EU residency documentation (UK Visas and Immigration (UKVI)) holds that entitlement to the NHS does not equate to having “comprehensive sickness insurance”.

The UK has implemented the Citizens’ Directive through the Immigration (European Economic Area) Regulations 2006.<sup>49</sup> The 2006 Regulations retain the Directive’s references to “comprehensive sickness insurance” without any amendments.<sup>50</sup> It bears emphasising here that national authorities like the UKVI do not actually have the power to *grant* EU nationals free movement rights, as these are guaranteed by EU law in art. 21 TFEU and the Citizens’ Directive;<sup>51</sup> instead, the UK authorities have an obligation to recognise those rights by issuing status confirmation documents.

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<sup>48</sup> 2011 Regulations, reg 24(3).

<sup>49</sup> The Immigration (European Economic Area) Regulations 2006 (SI 2006/1003)

<sup>50</sup> Valcke, “Five Years of the Citizens' Directive in the UK: Part 2” (2011) 25 J.I.A.N.L. 331.

<sup>51</sup> Citizens’ Directive, arts. 4 and 5 provide rights to exit and entry, and arts. 6, 7, and 16 provide the rights to reside for up to three months, between three months and five years, and permanently.

UKVI has made available its working definition of “comprehensive sickness insurance” in Modernised Guidance on “how it considers the free movement rights” of EU citizens,<sup>52</sup> as well as in instructions to UKVI “caseworkers” processing EU applications.<sup>53</sup> The Casework Instructions indicate that three possible documents can be included as proof of sickness insurance: first, home State coverage—as evidenced by the EHIC or Forms S1, S2 or S3—will suffice as proof of comprehensive sickness insurance for those in the UK on a temporary basis. In addition, the UKBA will consider a private health insurance policy document as proof of comprehensive sickness insurance if it will cover the EU citizen for “medical treatment in the majority of circumstances” during their stay in the UK.<sup>54</sup>

The Modernised Guidance states the following with regards to “comprehensive sickness insurance”:

“EEA nationals who must have medical insurance cannot rely on the NHS as providing medical insurance. Medical insurance must cover an existing medical conditions and any treatment that can be required for serious or long term medical conditions. EEA nationals and their family members must show that they will not be a burden on the public finances of the UK.”<sup>55</sup>

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<sup>52</sup> UK Visas and Immigration, "Casework Instructions: Chapter 4 - Registration Certificate Applications" (2014) <http://www.gov.uk/government/publications/european-casework-instructions> [Accessed April 9, 2014].

<sup>53</sup> UK Visas and Immigration, "European Economic Area (EEA) and Swiss nationals: free movement rights" (2014) <http://www.gov.uk/government/publications/eea-and-swiss-nationals-free-movement-rights> [Accessed April 9, 2014].

<sup>54</sup> UK Visas and Immigration, "Casework Instructions: Chapter 4 - Registration Certificate Applications", p. 13.

<sup>55</sup> UK Visas and Immigration, "European Economic Area (EEA) and Swiss nationals: free movement rights", p. 35.

Parts of this are non-controversial. Where temporary EU migrants are covered by social security institutions in their home States under Regulation 883/2004, the EHIC (and the related S forms for pensioners) allows European migrants to travel with and rely on their home State “comprehensive sickness insurance” cover.<sup>56</sup>

It is when economically inactive EU migrants do not retain social security cover in their home States that the UKBA’s definition of “comprehensive sickness insurance” is problematic—and, as discussed, under the current EU regime for coordinating social security, not all EU migrants *will* retain their home State cover.<sup>57</sup> Economically inactive migrants—regardless of if they are students, pensioners, or self-sufficient—are not *per se* habitually resident in their home Member States, as has been stressed recently in Commission guidance on how to apply the “habitual residence” test.<sup>58</sup> Current UK policy does not recognise this. As an example, UKVI and the Department of Health in the UK both assume that all migrant students are only studying in the UK on a temporary basis and remain habitually resident in their home State.<sup>59</sup> The Commission’s guidance, however, makes clear that a student enrolled in a degree programme in the UK may habitually reside there, such as when the student’s studies are funded by a UK body and the student has no demonstrable intention to leave

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<sup>56</sup> On the European coordination of patient mobility, see generally Willy Palm and Irene A. Glinos, “Enabling Patient Mobility in the EU: Between Free Movement and Coordination” in Mossialos and others (eds), *Health Systems Governance in Europe: The Role of European Union Law and Policy* (2010).

<sup>57</sup> See generally Schoukens and Pieters, “The Rules Within Regulation 883/2004 For Determining the Applicable Legislation” (2009) 11 E.J.S.S. 81.

<sup>58</sup> Commission, ‘Practical Guide’, p. 41-49.

<sup>59</sup> UK Visas and Immigration, “Casework Instructions: Chapter 4 - Registration Certificate Applications”, p. 13; see also Department of Health, “Guidance on Implementing the Overseas Visitors Hospital Charging Regulations” (October 2013). <http://www.dh.gov.uk/publications> [Accessed April 9, 2014], para. 7.18.

the UK.<sup>60</sup> The application of Regulation 883/2004 for the latter student results in coverage by UK social security; this student will thus not have a home State EHIC to present in the UK.

UKVI envisages that not all EU migrants will have an EHIC, but rather than instructing EU migrants “resident” in the UK under Regulation 883/2004 to submit evidence of NHS entitlement, it indicates that private health insurance may also suffice as evidence of “comprehensive sickness insurance”.

The Modernised Guidance and the Caseworker Instructions also describe a different level of coverage as required: where the Modernised Guidance requires coverage of pre-existing and chronic conditions, the Casework Instructions require cover in the “majority of circumstances”. The Modernised Guidance’s requirement is perhaps more on point. It is difficult to perceive of private insurance that does not cover pre-existing conditions as being “comprehensive”, since a pre-existing condition is much more likely to “burden” the host State healthcare system. However, the Casework Instructions appear to be taking a realistic view of what EU migrants *can* provide in terms of private cover; private health insurance obtained in the UK is highly unlikely to provide the same level of coverage that the NHS does.<sup>61</sup>

Some private cover, in other words, is treated as preferable to *none*; indeed, most important here is that both the Casework Instructions and the Modernised Guidance stress that entitlement to the NHS will not be considered as proof of having met the requirements set out by the Citizens’ Directive. The Modernised Guidance justifies this position by reference to the Court of Appeal judgment in *W (China) and X (China) v The Secretary of State for the Home Department*.<sup>62</sup>

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<sup>60</sup> Commission, para. 4.6-4.7.

<sup>61</sup> This has been found to be the case in the EU generally; see Thomson and Mossialos, “Private Health Insurance and the Internal Market” in *Health Systems Governance in Europe: The Role of European Union Law and Policy* (2010), p. 460.

<sup>62</sup> *W (China), X (China) v The Secretary of State for the Home Department* [2006] EWCA Civ 1494; [2007] 1 WLR

This case concerned the application of the ECJ's *Chen*<sup>63</sup> principle to two Chinese parents with a baby with Irish nationality. The parents were illegally in the UK at the time the case was decided, but were attempting to apply for EU residency rights as carers for their child (an Irish national) under Directive 90/364. The Court of Appeal agreed with the approach taken by the Immigration Appeal Tribunal, which interpreted *Chen* as meaning that the third country national (TCN) parent would need to meet the same requirements as an economically inactive EU migrant would, by being able to demonstrate self-sufficiency and the presence of sickness insurance.

*W and X* argued that W met the requirement for health insurance because his employment was subject to social security contributions; in other words, he was “paying for” NHS treatment much as any other employed UK resident does.<sup>64</sup>

Buxton LJ rejected this argument on two fronts. Firstly, he observed that, “in the case of the United Kingdom the requirement of sickness insurance was otiose, or automatically fulfilled, because health care was in any event available free of charge under the National Health Service.”<sup>65</sup> He dismissed this reasoning, however, stating that it “overlooks the fundamental reason for the insurance requirement that was identified as the basis of the scheme of the Directive in *Chen*: to prevent the

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<sup>63</sup> *Kunqian Catherine Zhu and Man Lavette Chen v Secretary of State for the Home Department* (C-200/02) [2004] E.C.R. I-09925, para. 47.

<sup>64</sup> *W and X* [2006] EWCA Civ 1494, para. 9.

<sup>65</sup> *W and X* [2006] EWCA Civ 1494, para. 10; on this, see also Filip van Overmeiren, Eberhard Eichenhofer and Herwig Verschueren, “Social Security Coverage of Non-Active Persons Moving to Another Member State” in Elspeth Guild, Cristina Gortázar Rotaecche and Dora Kostakopoulou (eds), *The Reconceptualization of European Union Citizenship* (Leiden: Brill Nijhof, 2014), pp. 253-254, noting that a lack of clarity on the relationship between the Citizens’ Directive and Regulation 883/2004 results in economically inactive migrants having automatic entitlement to “sickness insurance” in the host State once they are factually resident there.

presence of the EU citizen placing a burden on the host State. Use of free State medical services exactly creates such a burden.”<sup>66</sup>

Buxton LJ followed this up with a second argument as to why NHS entitlement does not equate to “sickness insurance”:

“It is also because of the nature of the NHS that the social security payments currently being made by W do not count as “insurance” for these purposes. The NHS scheme is not financed solely out of the social security scheme, but is largely tax-financed. Contribution to the social security fund cannot therefore serve as any sort of proxy for insurance designed to remove from the *taxpayer* the burden of providing health care.”<sup>67</sup>

In short, Buxton LJ did not dispute that the NHS is a health care *provider*, but stressed that it was not a health care *insurer*. The nature of its funding and its regulation of access means that reliance on the NHS runs anathema to the Directive’s purpose in requiring comprehensive sickness insurance in the first place: to prevent the UK finances from being ‘unreasonably burdened’ by economically inactive EU citizens. Consequently, he ruled that W and X had not satisfied the “sickness insurance” requirement, and thus did not have a right to reside in the UK on the basis of EU law.

Buxton LJ’s position has been reiterated in subsequent UK court judgments. Sullivan LJ in *FK (Kenya) v Secretary of State for the Home Department* found that:

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<sup>66</sup> *W and X* [2006] EWCA Civ 1494, para. 10.

<sup>67</sup> *W and X* [2006] EWCA Civ 1494, para. 11.

“A person who has to rely on the United Kingdom's National Health Service is no more self-sufficient than a person whose resources are inadequate so that he may become a burden on the United Kingdom's social assistance system.”<sup>68</sup>

Most recently, the Court of Appeal confirmed this interpretation of the Citizenship Directive's requirements in *Ahmad v Secretary of State for the Home Department*.<sup>69</sup> Strikingly, Arden LJ here accepted the following submission from counsel for the Secretary of State:

“Article 4 of Regulation 883/2004 provides that EU citizens "shall enjoy the same benefits and be subject to the same obligations under the legislation of any Member State as the nationals thereof". Under the UK's domestic social security legislation EU citizens who are entitled to free NHS treatment are provided with exactly the same access to care, and standard of care, as British nationals. So EU nationals from other Member States are not discriminated against under that Regulation. *Article 4 of the Regulation has no bearing on the correct application of the residence requirements in the Directive.*”<sup>70</sup> (emphasis added)

In the view of the Court of Appeal, then, as economically inactive EU migrants are permitted to *use* the NHS treatment they are entitled to, the UK has satisfied its obligations under Regulation 883/2004. However, such entitlement cannot be used to satisfy the requirements of the Citizenship's Directive. What this means in practice is that economically inactive EU migrants are permitted to *use* the NHS, but where they want confirmation of their EU residency rights or wish to apply for permanent residency in the UK, they must be able to demonstrate that they were not

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<sup>68</sup> *FK (Kenya) v Secretary of State for the Home Department* [2010] EWCA Civ 1302, para. 15.

<sup>69</sup> *Ahmad v Secretary of State for the Home Department* [2014] EWCA Civ 988

<sup>70</sup> *Ahmad* [2014] EWCA Civ 988, para. 39.



actually ever *reliant* on the NHS. Such an interpretation makes it challenging to describe “entitlement to the NHS” for these migrants as an EU-coordinated *benefit*.

#### *Alternative UK Interpretations of Comprehensive Sickness Insurance*

A first sign of disagreement with Buxton LJ’s interpretation is found within the *W and X* case itself, where Buxton LJ’s purposive interpretation seems to ignore the actual *wording* of the Directive.

Sedley LJ, despite ultimately agreeing with Buxton LJ, made the following observation:

“I would enter a caveat as to whether the Directive, when it speaks of [sickness insurance] is necessarily speaking of private health insurance. ... Nothing would have been easier, in the Directive and in the [Immigration] Rules, than to include the word “private” if that alone was what was meant – especially since, so far as I know, private insurance rarely if ever covers all risks, such as the risk of requiring long-term medical care.”<sup>71</sup>

Several subsequent UK judgments have explicitly<sup>72</sup> or implicitly<sup>73</sup> agreed with Sedley LJ’s observation. In the reasoned opinion it has sent to the UK, the Commission appears to follow this position as well.<sup>74</sup> The emphasis on *entitlement* in its opinion suggests that it finds that if economically inactive EU migrants are permitted to access the NHS under domestic law, such permission equates to having “comprehensive sickness insurance” cover in the UK.

Whereas UKVI and Buxton LJ focus on the Directive’s requirement of *insurance* so as to preclude an unreasonable public burden from being created on the UK, the Commission appears to have commenced infringement proceedings on the basis that the requirement for “comprehensive

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<sup>71</sup> *W and X* [2006] EWCA Civ 1494, para. 26.

<sup>72</sup> *AS v HM Revenue and Customs (CB)* [2013] NICom 15, para. 128(xii).

<sup>73</sup> *Secretary of State for Work and Pensions v SW* [2011] UKUT 508 (AAC), para. 20.

<sup>74</sup> Commission, “Free movement: Commission asks the UK to uphold EU citizens' rights (IP/12/417)”.

sickness insurance” is simply a requirement for *healthcare coverage* and consequently, entitlement to the NHS fully satisfies the requirement.

It is not clear how the UK government is contesting the Commission’s views. The *Financial Times* has reported that the Home Office disagrees with the Commission’s perspective on the UK position, and will argue that “the NHS cannot be seen as an insurance policy to anyone in the EU and that the controls are essential to ensuring economically inactive EU citizens do not place an undue burden on the State.”<sup>75</sup> This follows from what UKVI guidance and Buxton LJ also have alluded to: the Citizens’ Directive’s teleological aim of avoiding unreasonably burdening public finances of the Member States when extending residency rights to economically inactive EU citizens should guide any interpretation of what the Directive requires. As the purpose of requiring migrants to have “comprehensive sickness insurance” is to *avoid* a burden on the host State’s public finances, NHS entitlement cannot satisfy this requirement, as it creates a burden. However, the UK approach raises a crucial question about the Citizens’ Directive’s wording: when does a burden become *unreasonable*?

### **Possibilities for Excluding Economically Inactive EU Citizens from the NHS**

#### *Denying the Right to Reside: ‘Unreasonable Burden’*

The UK is not the only country that is struggling with EU migrant access to a national health system in the post-citizenship EU; for instance, Valcke observes similar problems in Spain and France.<sup>76</sup> The

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<sup>75</sup> Barker, "Britain falls foul of Brussels over immigration".

<sup>76</sup> Anthony Valcke, 'Five Years of the Citizens' Directive in the UK: Part 2' (2011) 25 J.I.A.N.L 331, p. 342. See also Greer, *The Politics of European Union Health Policies* (2009), pp. 97, 145; Simone Sandier, Valérie Paris and Dominique Polton, *Health Care Systems in Transition: France* (Geneva: WHO, 2004); Isabelle Durand-Zaleski,

costs of providing healthcare to all economically inactive residents of a Member State are potentially significant; the UK Department of Health's estimates make it clear that potentially, there are several hundreds of thousands of EEA migrants who—unless covered by social security in their home State—are not contributing to the NHS, but entitled to use it for free all the same.<sup>77</sup>

The ECJ's case law has historically respected that free movement has significant consequences for the financing of public services in the Member States, and that these consequences are potentially particularly severe for Member States that grant access to social benefits on the basis of residence. The EU's social security coordination regulations reflect these concerns; Regulation 883/2004's provisions on sickness and healthcare benefits require that where a pensioner collects a pension in one Member State and resides in another Member State, it is the State where the pensioner was economically active that will bear the cost of the healthcare provided in the State of residence.<sup>78</sup> In *Rundgren*, the ECJ discusses the operation of these coordination rules and notes that they exist to prevent "penalising" Member States that grant social security benefits on the basis of residence.<sup>79</sup> However, the Regulation manages to effectively coordinate responsibility for extending healthcare benefits for pensioners largely because pensioners *were* workers at one time, and consequently have paid contributions to at least one social security system. What of the economically inactive, who are either too young to have contributed—as will be true for many students—or, for any other reason, have simply not been covered by home State social security?

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"The French Health Care System" (2008).

[http://www.commonwealthfund.org/usr\\_doc/France\\_Country\\_Profile\\_2008.pdf](http://www.commonwealthfund.org/usr_doc/France_Country_Profile_2008.pdf) [Accessed April 9, 2014].

<sup>77</sup> Department of Health, "2012 Review of overseas visitors charging policy (Summary Document)" (April 2012).

<http://www.gov.uk/dh> [Accessed April 9, 2014].

<sup>78</sup> Regulation 883/2004, art. 24(2)(b).

<sup>79</sup> *Sulo Rundgren* (C-389/99) [2001] E.C.R. I-03731, para. 45.

For such migrants, it is exclusively host State domestic law that determines if they are entitled to access public healthcare systems. In the case of a health care system that operates on a social insurance basis, the EU migrant will be able to *buy* participation in the system on equivalent grounds to all national residents as well as all economically active EU migrant residents.<sup>80</sup> In a health care system that operates on a residency basis alone, however, there is no option for “buying” access. National law such as that of the UK simply grants access. In recognition of this, the Citizenship Directive permits Member States to declare economically inactive EU migrants to be an “unreasonable burden” if they rely on the benefits to which they are legally entitled to an “unreasonable” extent. Being declared such a burden would then deprive them of a right to reside in the host State.<sup>81</sup> Additionally, the Citizenship Directive excludes certain types of benefits from its equal treatment principle, largely because they would pose an ‘unreasonable burden’; an example that has been subject to much case law is study financing, which does not have to be extended to migrant EU students until they have obtained permanent residence, per art. 24(2) of the Directive.<sup>82</sup>

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<sup>80</sup> See, for instance, on access to the Dutch healthcare system, Rosenau and Lako, “An Experiment with Regulated Competition and Individual Mandates for Universal Health Care: The New Dutch Health Insurance System” (2008) 33 J.H.P.P.L. 1031.

<sup>81</sup> It has been argued that the concept of a “burden” does not strictly apply to the sickness insurance requirement on a reading of art. 7 of the Directive; see van Overmeiren, Eichenhofer and Verschueren, “Social Security Coverage of Non-Active Persons Moving to Another Member State” in *The Reconceptualization of European Union Citizenship* (2014), p. 254. It is submitted here that the ECJ’s generally purposive/contextual approach to statutory interpretation is likely to result in a less literal interpretation of art. 7.

<sup>82</sup> See *The Queen, on the application of Dany Bidar v London Borough of Ealing and Secretary of State for Education and Skills* (C-209/03) [2005] E.C.R. I-02119; *Jacqueline Förster v Hoofddirectie van de Informatie Beheer Groep* (C-158/07) [2008] E.C.R. I-08507.

Unfortunately, what constitutes an “unreasonable” burden has been very differently interpreted in different Member States.<sup>83</sup> The Citizens’ Directive itself does not provide a definition; it merely suggests in its preamble that Member States, in determining if a migrant EU citizen presents such a burden, must “examine whether it is a case of temporary difficulties and take into account the duration of residence, the personal circumstances and the amount of aid granted .”<sup>84</sup> The ECJ’s brief comments in *Grzelczyk*, concerning a student’s ability to request a social security benefit in his host State, confirm that these were the relevant factors for the referring court to consider in determining if Mr. Grzelczyk was an unreasonable burden on Belgium.<sup>85</sup> Similarly, in *Bidar* and *Förster*, the ECJ considered the extent of duration of students applying for study financing in determining if the burden they presented was ‘unreasonable’.<sup>86</sup> Additionally, as *Baumbast* demonstrates, the ECJ has required that any restriction on access to benefits of an EU migrant must be proportionate in light of the extent of burden that the individual migrant poses.<sup>87</sup> *Baumbast* and *Grzelczyk* thus suggest that the current blanket rule applied by the UKVI, which simply states that entitlement to the NHS is in no circumstances evidence of “comprehensive sickness insurance”, is likely disproportionate.

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<sup>83</sup> See generally, Paul Minderhoud, “Directive 2004/38 and access to social assistance benefits” (2011) 18 J.S.S.L. 153; Sergio Carrera and Anais Faure Atger, “Implementation of Directive 2004/38 in the context of EU Enlargement: A proliferation of different forms of citizenship?” (CEPS Special Report, April 2009). <http://www.ceps.eu> [Accessed April 9, 2014].

<sup>84</sup> Citizens’ Directive, recital 16.

<sup>85</sup> See paras. 44-45 in *Rudy Grzelczyk v Centre public d’aide sociale d’Ottignies-Louvain-la-Neuve* (C-184/99) [2001] E.C.R. I-06193; see also Anastasia Iliopoulou and Helen Toner, “Case Note: *Grzelczyk*” (2002) 39 C.M.L.Rev 609, p. 611.

<sup>86</sup> *Bidar* [2005] E.C.R. I-02119, para. 59-62; *Förster* [2008] E.C.R. I-08507, para. 50-55.

<sup>87</sup> *Baumbast* [2002] E.C.R. I-07091, paras. 90-93. See additionally *Grzelczyk* [2001] E.C.R. I-06193; *Chen* [2004] E.C.R. I-09925, paras. 27-33, and for commentary, Michael Dougan and Eleanor Spaventa, “Educating Rudy and the Non-English Patient: A Double Bill on Residency Rights under Article 18 EC” (2003) 28 E.L.Rev 697.

In picking apart the Citizens' Directive's description of what constitutes an unreasonable burden, however, the problem that the UK is faced with becomes apparent. For one, *entitlement* to the NHS does not equate to *reliance* on the NHS. NHS entitlement is not akin to the collection of other types of benefit, where a cash transfer of public finance to the benefit claimant means that a monetary 'burden' exists immediately;<sup>88</sup> instead, entitlement to the NHS is principally cost-free unless an economically inactive EU migrant actually presents with healthcare needs. It will be very difficult for the UK government to demonstrate that an economically inactive EU migrant who has *never* used NHS services when applying for confirmation of permanent residency was nonetheless an "unreasonable burden" on UK public finances.<sup>89</sup>

More worryingly, applying a proportionality assessment to any reliance on the NHS will require UK authorities to evaluate not only, as per *Grzelczyk*, how integrated into the UK a claimant is but also how much of a drain they have been on public finances. Compliance with the Directive's proposed evaluation of the extent of 'burden' that is posed by an EU migrant is thus likely to require every applicant for EU residency documentation to print off an itemized, dated bill of their healthcare costs, so that UKVI can make a proportionate determination of the 'reasonableness' of their burden on public finances. National measures short of such an individual assessment would not satisfy the EU's proportionality test. The UK courts appear to recognize this: in *Ahmad*, Arden LJ distinguished *Baumbast* by noting that "Mr Baumbast did not make any calls on the National Health Service

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<sup>88</sup> As was the case in *Grzelczyk* [2001] E.C.R. I-06193.

<sup>89</sup> In *Ahmad* [2014] EWCA Civ 988, para 51, counsel for the Secretary of State argued that it is proportionate to require economically inactive migrants to hold sickness insurance, as otherwise "the host [would be] at risk of having to assume the consequences of the absence of insurance." Arden LJ accepted this reasoning, but in the view of the author, there is no reason to assume on the basis of the ECJ's existing case law that it would agree.

whereas Mrs Ahmad has had two children since she arrived in the UK”, and consequently their individual factual circumstances were incomparable.<sup>90</sup>

How *much* reliance on publicly-funded social security by economically inactive EU migrants is ‘unreasonable’ has not been clarified by the ECJ. Academic commentary has been sceptical: Hailbronner has argued that it is inconceivable that any one claimant of social security can actually affect public finances to an extent where they, individually, are an unreasonable burden.<sup>91</sup> Other commentators seem to generally agree that the ECJ’s methodology for determining when a burden is unreasonable has meant that very few individual economically inactive EU migrants will qualify for this status.<sup>92</sup> Unless they do, however, Member States have no option but to consider their benefit applications on their merits: the Citizens’ Directive stresses expulsion can never be the automatic consequence of applying for benefits, which suggests that relying on *entitlement* to the NHS cannot result in a revocation of residency rights.<sup>93</sup>

The current UKVI approach of treating entitlement to NHS treatment as never being evidence of “comprehensive sickness insurance” thus seems untenable. Neither EU law nor guidance suggests that NHS entitlement somehow *is not* a form of comprehensive sickness insurance. Additionally, while the ECJ does not appear unsympathetic to the UK’s concerns regarding economically inactive migrants relying on the NHS, its case law also strongly suggests that UKVI’s current policy is disproportionate. In *Baumbast* the Court could have declared that *any* reliance on the NHS by economically inactive EU migrants would be an unreasonable burden, but it focused instead on the

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<sup>90</sup> *Ahmad* [2014] EWCA Civ 988, para. 46.

<sup>91</sup> Hailbronner, “Union Citizenship and Access to Social Benefits” (2005) 42 C.M.L.Rev 1245, p. 1260.

<sup>92</sup> Alexander Somek, “Solidarity Decomposed: Being and Time in European Citizenship” (2007) 32 E.L.Rev 787, pp. 799-800; Minderhoud, “Directive 2004/38 and access to social assistance benefits” (2011) 18 J.S.S.L. 153, p. 165.

<sup>93</sup> Citizens’ Directive, art. 14(3).

Baumbast family's specific circumstances. While some migrants may thus be an unreasonable burden, any such determination made by the UK must be supported by an individualised assessment.

This does not resolve the UK's conundrum. Administratively, the prospect of needing to consider how entitlement to and/or reliance on the NHS affects each individual EU migrant's ability to claim a right to reside would drastically increase the cost of processing EU residency documentation – and, as O'Leary has argued, would at best create a different type of burden on UK public finances.<sup>94</sup>

An alternative solution to the problem outlined above would be to change domestic access entitlements to the NHS so that economically inactive EU migrants no longer *can* rely on the NHS. However, this is likely to lead to other difficulties, as EU law indirectly but significantly impacts how access to the NHS can be regulated.

#### *Restricting Entitlement to the NHS: Equal Treatment and 'Real Links'*

If the UK wishes to restrict the NHS care entitlement of economically inactive EU migrants, it must find means of doing so that do not violate EU law. This is made difficult by the art. 18 TFEU prohibition of discrimination on the grounds of nationality, given particular context for EU citizens by the equal treatment right articulated in art. 24 of the Citizens' Directive.<sup>95</sup> Art. 18 TFEU forbids discrimination on the grounds of nationality (*de jure* or *de facto*) insofar as an area of domestic law is within the EU Treaties' material scope, albeit with several exceptions found in secondary legislation: as noted, student maintenance grants are potentially excluded by art. 24(2) of the Citizens' Directive, as is "social assistance" within the first three months of residing in a host State.

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<sup>94</sup> O'Leary, "Developing an Ever Closer Union Between the Peoples of Europe?", p. 14.

<sup>95</sup> See also art. 4 of Regulation 883/2004, which requires equal treatment between EU migrants and nationals of the competent State.



In considering the possibility of restricting NHS access, in determining if art. 24(2) of the Citizens' Directive means that entitlement to the NHS *can* be restricted for the first three months of EU citizens' residence in the UK, it is necessary to consider what the Citizens' Directive means by "social assistance".

In *Brey*,<sup>96</sup> the ECJ has for the first time considered "social assistance" in the context of the Citizens' Directive, and defined it as:

"all assistance introduced by the public authorities... that can be claimed by an individual who does not have resources sufficient to meet his own basic needs and the needs of his family and who, by reason of that fact, may become a burden on the public finances of the host Member State during his period of residence..."<sup>97</sup>

In the ECJ's view, "social assistance" in art. 24 therefore refers to publicly funded assistance that migrants become dependent upon because they lack *sufficient resources*. NHS access, however, is not a resource-dependent or means-tested benefit; it cannot be "paid for" even by those who do have sufficient resources to not burden the public finances of the UK. Under the *Brey* definition, access to the NHS is not a form of "social assistance".<sup>98</sup>

If NHS entitlement is not deemed to be "social assistance", withdrawing access rights for economically inactive EU migrants is impermissible under EU law, both in the first three months of residence and in the subsequent years. Art. 24(1) of the Citizens' Directive and Article 4 of Regulation 883/2004 both require equal treatment with host State nationals in comparable

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<sup>96</sup> *Pensionsversicherungsanstalt v Peter Brey* (Case C-140/12 ) September 13, 2013.

<sup>97</sup> *Brey* (Case C-140/12), para. 61.

<sup>98</sup> This argument has been made by Valcke, "Five Years of the Citizens' Directive in the UK: Part 2" (2011) 25 J.I.A.N.L. 331, in light of the ECJ's interpretation of "social assistance" in Council Directive 2003/86/EC of 22 September 2003 on the right to family reunification [2003] OJ L251/12, in *Rhimou Chakroun v Minister van Buitenlandse Zaken* (C-578/08) [2010] E.C.R. I-01839.

positions. Thus, if every economically inactive UK national has a right to use the NHS on account of residing in the UK, every economically inactive EU national resident in the UK would similarly be entitled; any alternative would be discriminatory on the grounds of nationality.<sup>99</sup>

The ECJ has, however, recognised that granting access to publicly funded social security to all economically inactive EU migrants may make domestic social security systems unsustainable. It has therefore held that it is permissible for Member States to restrict access to benefits only to those migrants who can demonstrate a “real link” or a “genuine link” to the host State.<sup>100</sup> The concept of a “real link” was introduced in *D’Hoop*, and has since been applied by the ECJ in cases where Member States wish to justify restrictions on social security benefits. In doing so, the ECJ has held that “the proof required to demonstrate the genuine link must not be too exclusive in nature or unduly favour one element which is not necessarily representative of the real and effective degree of connection between the claimant and the Member State...”<sup>101</sup> Additionally, in *Commission v Austria*, the ECJ stressed that “the genuine link required ... need not be fixed in a uniform matter for all benefits, but should be established according to the constitutive elements of the benefit in question.”<sup>102</sup> How would such a “real link” look with regards to NHS access as the benefit in question?

The first difficulty of a “real link” test is that it, too, requires a proportionate examination of the circumstances of any particular applicant. The ECJ’s suggested approaches to such an examination

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<sup>99</sup> On this reasoning, see Iliopoulou and Toner, “Case Note: Grzelczyk” (2002) 39 C.M.L.Rev 609; Catherine Barnard, *The Substantive Law of the EU: The Four Freedoms*, 4 edn (Oxford: OUP, 2013), p. 466.

<sup>100</sup> See *Marie-Nathalie D’Hoop v Office national de l’emploi* (C-224/98) [2002] E.C.R. I-06191, para. 38; see also, inter alia, *Bidar* [2005] E.C.R. I-02119; *Commission v Austria* (C-75/11) October 4, 2012; *Laurence Prinz v Region Hannover and Philipp Seeberger v Studentenwerk Heidelberg* (C-523/11 and C-585/11) July 18, 2013; and *Andreas Ingemar Thiele Meneses v Region Hannover*, (C-220/12) October 24, 2013.

<sup>101</sup> See, most recently, *Meneses* (C-220/12), para. 36.

<sup>102</sup> *Commission v Austria* (C-75/11), para. 63.

are occasionally generous; for instance, in *Commission v Austria*, the ECJ held that evidence that a student is actually *studying* in Austria would be an appropriate indicator of a “real link” between a student and the host State.<sup>103</sup> Assessment in relation to unemployment benefits has followed a similar logic: having sought work in the host State for some time suffices in demonstrating a “genuine link” between a jobseeker and the host State.<sup>104</sup>

This reasoning cannot be extended to benefits applied for by the generally economically inactive; it is difficult to imagine what, beyond residence, could demonstrate a “link” between an economically self-sufficient EU migrant and the host State. The ECJ has in principle permitted residency to be used as a measure of a connection to the host State, but has not established clear threshold durations in its case law: what it would deem to be an appropriate amount of “residence” to demonstrate a “real link” to the UK for the purposes of relying on NHS entitlement is at best guesswork.

Different assessments of “residence” have very different implications for the host State. For instance, it has been argued that as “habitual residence” under Regulation 883/2004 acts as a sufficient connection to the host State to make it competent for social security, what Regulation 883/2004 is measuring in examining habitual residence is analogous to a “real link”. Such a “link” is not dependent on the duration of residence; it can, depending on the migrant’s circumstances, be instantaneous once the migrant starts *living* in the host State.<sup>105</sup>

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<sup>103</sup> *Commission v Austria* (C-75/11), para. 64.

<sup>104</sup> See *Brian Francis Collins v Secretary of State for Work and Pensions* (C-138/02) [2004] E.C.R. I-02703; *Athanasios Vatsouras and Josif Koupatantze v Arbeitsgemeinschaft (ARGE) Nürnberg 900* (C-22/08 and C-23/08) [2009] E.C.R. I-04585; *Lucy Stewart v Secretary of State for Work and Pensions* (C-503/09) [2011] E.C.R. I-06497

<sup>105</sup> van Overmeiren, Eichenhofer and Verschuere, “Social Security Coverage of Non-Active Persons Moving to Another Member State” in *The Reconceptualization of European Union Citizenship* (2014), pp. 256-258.

Conversely, the ECJ's guidance to national authorities suggests that a "reasonable period" of residence may demonstrate a "real link".<sup>106</sup> However, *Stewart* makes it clear that *requiring* a "reasonable period" of residence would nonetheless violate the proportionality principle, as it excludes all other possible means by which a claimant could demonstrate a connection to the host State.<sup>107</sup> The difficulties inherent to a "real link" investigation are thus similar to those produced by the "unreasonable burden" test outlined above: proving that there is *no* genuine link would require the UK, at significant cost, to consider all possible relevant indicators of connectedness in an economically inactive EU migrant's life.

There are additional problems with only entitling economically active EU migrants with "real links" to NHS access, and these stem from the fact that a non-discriminatory version of such a test will negatively affect migrant UK nationals. Much like potential EU citizen migrants, UK nationals who have lived abroad may struggle to demonstrate the existence of such a link without resorting to their nationality as supporting evidence; but doing so would be precluded by art. 18 TFEU.<sup>108</sup> Recent Department of Health<sup>109</sup> and Home Office<sup>110</sup> consultations on amending the NHS access rules—where "ordinary residence" is perceived as too easily met by non-EEA migrants, in light of growing

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<sup>106</sup> *Stewart* [2011] E.C.R. I-06497, paras 92-93.

<sup>107</sup> *Stewart* [2011] E.C.R. I-06497, paras. 94-95; see also *D'Hoop* [2002] E.C.R. I-06191, para. 39.

<sup>108</sup> Gareth Davies, "'Any Place I Hang My Hat?' or: Residence is the New Nationality" (2005) 11 E.L.J. 43, pp. 53-56; see also Keleigh Coldron and Louise Ackers, "(Ab)using European Citizens? EU Retired Migrants and the Exercise of Healthcare Rights" (2007) 14 M.J. 287, p. 299.

<sup>109</sup> Department of Health, "Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England" (July 2013). <http://www.gov.uk/dh> [Accessed April 9, 2014].

<sup>110</sup> Home Office, "Controlling Immigration – Regulating Migrant Access to Health Services in the UK (Consultation document)" (July 2013). <http://www.gov.uk/government/organisations/home-office> [Accessed April 9, 2014].

funding pressures for the NHS—suggest that the political will to exclude migrant UK nationals from NHS access is absent; the proposals under consultation would actually extend coverage for UK nationals residing abroad. The “real link” test thus offers no better solutions to the UK than the “unreasonable burden” test does: economically inactive EU migrants cannot generally be denied entitlement to NHS treatment without this resulting in violations of EU law.

#### *National Health Services and EU Law: Compatible?*

The cost of economically inactive EU migrants relying on public health services is unlikely to affect social insurance-style health care systems to the same extent. In insurance-based systems there is general scope for ensuring that migrants pay into the system, regardless of whether or not they are economically active, as the systems are organised in such a way that *all* residents pay insurance premiums to support their healthcare. There is far less scope for mitigating migrant health costs under the operating principles of a national health service.<sup>111</sup>

Nothing in law stops the UK from requiring financial input from all economically inactive NHS users;<sup>112</sup> the Irish public health service, for instance, applies a nominal charge to hospital stays for all Irish residents.<sup>113</sup> However, taking such a step would fundamentally change the NHS from a universal, ‘free at the point of use’ service to a system with significant insurance-style traits. Every economically inactive UK resident, regardless of nationality, would have to pay a fixed fee so as to

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<sup>111</sup> See Hatzopoulos, “Health Law and Policy: The Impact of the EU” in *EU Law and the Welfare State: in Search of Solidarity* (2005), p. 116; van der Mei, *Free Movement of Persons Within the European Community: Cross-Border Access To Public Benefits* (2003), p. 224; Oliver and Mossialos, “European Health Systems Reforms: Looking Backward to see Forward?” (2005) 30 J.H.P.P.L. 7, pp. 13-14.

<sup>112</sup> As also observed by Valcke, “Five Years of the Citizens’ Directive in the UK: Part 2” (2011) 25 J.I.A.N.L. 331.

<sup>113</sup> See Citizens Information, “Charges for Hospital Services” (2014). *citizensinformation.ie*, [http://www.citizensinformation.ie/en/health/hospital\\_services/hospital\\_charges.html](http://www.citizensinformation.ie/en/health/hospital_services/hospital_charges.html) [Accessed April 9, 2014].

not unduly burden UK public finances; and granting free treatment only to returning, retired UK expatriates would not be possible under such a system, as they would find themselves in an identical position to newly-resident economically inactive EU migrants.<sup>114</sup>

Additionally, there are substantial practical difficulties in introducing such changes to the NHS. Given that to date there have never been charges for most NHS care services, setting the level of an appropriate payment would not be straight-forward; this is confirmed by the Department of Health's 2013 consultation on charging for TCN migrant healthcare, which alludes to undescribed "other factors" to consider when setting the level of such a migrant charge.<sup>115</sup> The ECJ is unlikely to be sympathetic to any difficulties involved in introducing a fee payment for NHS access rights, however. In *Watts*, the UK was simply told that being an EU Member State "inevitably" resulted in some changes needing to be made to the operation of its social services.<sup>116</sup>

Even in an area of welfare regulation where the EU has no competence to act, there thus seems to be a significant pull from the internal market towards further convergence of approach. Moreover, such a converged approach is far more likely to have the traits of the market-oriented purchased health care systems than the traits of the more socially-oriented national health services, as the EU's decades-old law on both freedom of movement of persons and social security only truly accommodates the social insurance setup.

## Conclusion

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<sup>114</sup> See Davies, "'Any Place I Hang My Hat?' or: Residence is the New Nationality" (2005) 11 E.L.J. 43.

<sup>115</sup> Department of Health, "Sustaining services, ensuring fairness: A consultation on migrant access and their financial contribution to NHS provision in England", p. 19. See also Davies, "The Community's Internal Market-Based Competence to Regulate Healthcare: Scope, Strategies and Consequences" (2007) 14 M.J. 215, pp. 232-234.

<sup>116</sup> *Watts* [2006] E.C.R. I-04325, para. 121.

Member States retain the competence to organize their national healthcare systems as they see fit, but this may be little consolation to them given that EU law nonetheless has significant effects on how they can organize healthcare in practice. It is clear that the Commission disagrees with the UK position on whether or not the NHS functions as a comprehensive sickness insurance provider and, as has been shown, excluding all economically inactive migrants from NHS entitlement appears impermissible under EU law. What does that mean for national health services at a time when the pressures on healthcare funding are mounting? Will governments remain willing to operate systems like the NHS if many economically inactive EU migrants have a right to access them without contributing to host State public finances?

The only proven manner of putting an end to negative spill-over effects of European integration in national healthcare regulation has been to integrate further voluntarily.<sup>117</sup> The discussed pull of the internal market towards an insurance-based, market-oriented system suggests strongly that it is in the Member States' best interest to legislate on coverage of economically inactive EU citizens sooner rather than later. National health services facing the free movement of all EU citizens can only find protection in the further coordination of social security rules at the EU level: in particular, more explicit and generally applicable rules allocating responsibility for social security coverage of the economically inactive will result in the most effective and equitable solution to the described problem,<sup>118</sup> if the more radical suggestion to revise Regulation 883/2004 and always make the state of residency competent for healthcare services remains politically untenable.<sup>119</sup> Nebulous concepts

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<sup>117</sup> See Hatzopoulos and Hervey, 'Coming into line: the EU's Court Softens on Cross-Border Health Care' (2013) 8 Health Economics, Policy and Law 1, discussing the Patients' Rights Directive.

<sup>118</sup> Proposals to re-coordinate the coordination of social security systems have also recently been highlighted in van Overmeiren, Eichenhofer and Verschueren, "Social Security Coverage of Non-Active Persons Moving to Another Member State" in *The Reconceptualization of European Union Citizenship* (2014), Pt. III.

<sup>119</sup> See Schoukens and Pieters, "The Rules Within Regulation 883/2004 For Determining the Applicable Legislation" (2009) 11 E.J.S.S. 81, p. 105.

such as a “genuine link” or an “unreasonable burden” are clearly not fully capable of protecting systems like the NHS, but that does not mean solutions at the EU level *cannot* be found. Establishing an EU-level coordinating regime that, for example, requires the home State to provide “comprehensive sickness insurance” for economically inactive migrants until they obtain permanent residence would not only be more manageable from a domestic administrative perspective, but also would result in more security for migrants regardless of how aware they are of their EU rights, and would achieve the goal of Regulation 883/2004: no migrants would find themselves without social security cover. Such a five year coverage exclusion is not unprecedented, either: its codification in the Citizens’ Directive has assuaged host Member State concerns about being made to pay for migrating students.<sup>120</sup> More importantly, perhaps, it has become clear that the ECJ will respect such a lengthy exception to equal treatment if EU secondary legislation requires it, resulting in far greater legal certainty for migrating students and Member States alike.<sup>121</sup> Verschueren observes correctly that the main shortcoming of the student maintenance exclusion is that the Citizens’ Directive does not require the home State to *continue* providing maintenance aid for students *until* they achieve permanent residence. Functional coordination would therefore not merely absolve the host State from providing an EU citizen’s sickness insurance coverage, but also designate the home State as responsible for providing it.<sup>122</sup> If student maintenance is any indication, the alternative to EU-level legislation is the risk of ongoing litigation before the Court of Justice.<sup>123</sup>

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<sup>120</sup> Citizens’ Directive, art. 24(2).

<sup>121</sup> *Förster* [2008] E.C.R. I-08507.

<sup>122</sup> Herwig Verschueren, 'EU Free Movement of Persons and Member States' Solidarity Systems: Searching for a Balance' in Elspeth Guild and Paul Minderhoud (eds), *The First Decade of EU Migration and Asylum Law* (Martinus Nijhoff 2012), p. 72.

<sup>123</sup> See, recently, *Prinz and Seeberger* (C-523/11 and C-585/11); *Giersch v Luxembourg* (C-20/12) February 7, 2013; *Commission v Netherlands* (C-542/09 ) February 16, 2012.



Agreement on more explicit coordination will undoubtedly be an arduous and lengthy process.

Unlike awaiting what the ECJ might think of the specific requirements in the Citizens' Directive and its interaction with Regulation 883/2004, however, such a legislative solution will allow the Member States to give meaning to the fact that they have retained exclusive competence over regulating their healthcare systems in the post-citizenship EU.